HUMAN SERVICES

DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

Dental Services

Revised Prior Authorization and Reimbursement Procedures for Dental Services

Proposed Amendments: N.J.A.C. 10:56-1.2, 1.3, 1.4, 1.5, 1.8, 1.9, 1.10, 2.1, 2.2, 2.4, 2.7, 2.8, 2.10, 2.11, 2.12, 2.14, 2.15, 2.16, 2.18, 2.19, 2.21, 3.1, 3.2, 3.6 and 3.10

Authorized by: Gwendolyn L. Harris, Commissioner,
Department of Human Services.

Authority: N.J.S.A. 30:4D-1 et seq., specifically 7 and 12.
CFR 42 440.100, Section 1902(a), 42U.S.C. 1396a, and Sections 2101 through 2103 of the Social Security Act, 42 U.S.C. 1397aa, 1397bb, 1397cc and 1397jj.

Calendar Reference: See Summary below for explanation of the exception to the rulemaking calendar requirements.

Agency Control Number: 03-P-18.

Proposal Number: PRN 2003 - .

Submit comments by **to:**

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The agency proposal follows:

Summary

The Division of Medical Assistance and Health Services is proposing amendments to N.J.A.C. 10:56, Dental Services to address changes in the provision of, and reimbursement for, dental services rendered to eligible Medicaid/NJ FamilyCare beneficiaries. The proposed amendments specifically address the discontinuation of the prior authorization requirement for specified dental procedures related to root canals and crowns, the revision of prior authorization procedures related to periodontal services and revise reimbursement for specified oral evaluations and orthodontic procedures.

Throughout the chapter, the Division is proposing to amend the references to "NJ KidCare" to read "NJ FamilyCare," to more accurately indicate the name of the program. When the rules implementing the NJ KidCare program (see 30 N.J.R. 713(a) and 30 N.J.R. 304(a)) were adopted, text was added indicating that unless otherwise specified, all Medicaid program rules were equally applicable to NJ KidCare. When the rules implementing NJ FamilyCare became effective on September 5, 2000 (see 32 N.J.R. 3603(a)), NJ FamilyCare subsumed NJ KidCare. Adding references to NJ FamilyCare to N.J.A.C. 10:77 does not represent a change in Division policy, but simply an updating of the text.

At N.J.A.C. 10:56-1.4, Prior authorization, "Office of Utilization Management" has been inserted in the mailing address to more accurately represent the office to which the prior authorization requests are to be submitted. Also, language has been inserted to clarify that the claim form for the services must accompany the authorization request.

At N.J.A.C. 10:56-2.10(a)2, is being amended to remove references to prior authorization for related to crown restoration since the Division will no longer be requiring providers to obtain prior authorization to seek reimbursement for the provision of this dental service.

N.J.A.C. 10:56-2.11(a) and N.J.A.C. 10:56-2.11(b)1, related to prior authorization requirements for root canal procedures, are proposed to be deleted since the Division will no longer be requiring providers to obtain prior authorization to seek reimbursement for the provision of this dental service. Accordingly, current N.J.A.C. 10:56-2.11(b) is proposed to be recodified, without change, as N.J.A.C. 10:56-2.11(a), and current N.J.A.C. 10:56-2.11(b)2 and 3 being recodified, without change, as N.J.A.C. 10:56-2.11(a)1 and 2 to allow for the deletions and recodifications described above.

At N.J.A.C. 10:56-2.12, Periodontal treatment, a new N.J.A.C. 10:56-2.12(a) is proposed stating that reimbursement for periodontal treatment of up to eight quadrants annually will be provided without prior authorization.

N.J.A.C. 10:56-2.12(a) is proposed to be recodified as N.J.A.C. 10:56-2.12(b), adding the word "Additional" to the first sentence to indicate that periodontal treatment exceeding eight quadrants annually shall require prior authorization for reimbursement.

Current N.J.A.C. 10:56-2.12(b)–(d) are being recodified, without change to text, as N.J.A.C. 10:56-2.12(c)–(e) to allow for these amendments.

At N.J.A.C. 10:56-2.19 and 2.21(a)13, the Division is proposing to amend the references to "Medicaid District Office (MDO)" to read "Medical Assistance Customer Centers (MACC)" to reflect the name change of these offices as authorized by the Commissioner of the Department of Human Services.

Throughout N.J.A.C. 10:56-3, the Division is proposing to amend all references to "Health Care Financing Administration" or "HCFA" to read "Centers for Medicare & Medicaid Services" or "CMS" to reflect the name change of the agency. This does not represent any change in Federal or State policy, simply an updating of the text to accurately reflect the name of the Federal agency.

At N.J.A.C. 10:56-3.2(a), Clinical oral examination, the reimbursement for the procedure code D0120, for periodic oral evaluations, is being increased by $1.00. This brings the reimbursement for a specialist to $15.00 and the reimbursement for a non-specialist to $14.00.

At N.J.A.C. 10:56-3.6(a), Periodontics, the indicators on the HCPCS D4210, D4211 D4220, D4260 and D4270 are being changed to indicate that prior authorization is required only in special circumstances. Notes are being added below the groupings containing these HCPCS codes explaining that prior authorization for periodontal codes is only required when exceeding four quadrants, twice annually. The HCPCS code D4261, related to periodontal services and their corresponding maximum fee allowances are proposed to be added, in numerical order, to this rule. These procedure codes are being added to the list because they were adopted by the CMS Healthcare Common Procedure Coding System, effective for services provided on or after January 1, 2003.

At N.J.A.C. 10:56-3.6(a), Periodontics, the indicators on the HCPCS D4341 is being changed to indicate that prior authorization is required only in special circumstances. A note is being added below the list of HCPCS codes explaining that prior authorization for D4341 is only required when exceeding four quadrants, twice annually

The Department has determined that the comment period for this proposal will be 60 days; therefore, pursuant to N.J.A.C. 1:30-3.3(a)5, this proposal is exempted from the rulemaking calendar requirement.

Social Impact

The proposed amendments will have a positive impact on all Medicaid/NJ FamilyCare fee-for-service beneficiaries, because the amendments assure continued coverage of dental services and do not change the scope of eligibility for services.

The amendments are expected to have a positive impact on providers of dental services, since prior authorization (PA) requirements will not be needed for specified HCPCS procedure codes if they do not exceed the utilization thresholds described within this rulemaking. Any increase or decrease in the amount of reimbursement received will be a result of the volume of service provided by the individual practitioner.

Economic Impact

The Division of Medical Assistance and Health Services (DMAHS) reviews and adjusts the procedure coding system on an annual basis to accurately reflect and revise the Centers for Medicaid & Medicare's Healthcare Common Procedure Coding System (HCPCS). The economic impact of these proposed amendments should have a minimal economic effect on the budget of the Division. The coverage of new dental procedures is a normal occurrence of health care coverage and these amendments are not expected to generate a significant increase in the reimbursements paid to the providers. The proposed amendments adjusting the reimbursement amounts for the specified procedures are expected to have a positive economic impact on providers of these services, since they will be able to receive increased reimbursement for the provision of services.

The proposed amendments will have no economic impact of the beneficiaries, since Medicaid/NJ FamilyCare—Plan A beneficiaries do not contribute to the cost of their medical care. NJ FamilyCare beneficiaries who are required to pay a co-payment for covered dental services will continue to pay the same co-payment.

The proposed amendments may have a positive impact on the State, in that the staff time required to process requests for prior authorization will be reduced since not as many procedures will now require prior authorizations to be processed.

Federal Standards Statement

Federal regulations (42 C.F.R. 440.100) and Social Security Act §1902(a)(10) and §1905(a)(10) (42 U.S.C. §1396a(a)(10)) allow for dental services to be provided under the New Jersey Medicaid/NJ FamilyCare fee-for-service program. However, there is little specificity in the Federal regulations as to the type of dental services that can be provided. Therefore, states are able to develop their own programs and corresponding fee schedules, subject to Federal approval.

Federal statutes covering Title XXI allow a state, at its option, to provide a State Child Health Insurance Plan (SCHIP). New Jersey has elected this option with the development of the NJ FamilyCare Program. Federal statute (Title XXI) governing NJ KidCare - Plans B and C are broad guidelines and expect State to adopt regulations in order to assure the quality of services provided to NJ FamilyCare - Plans B and C enrollees. Sections 2103 and 2110 of the Social Security Act (42 U.S.C. 1397cc and 1397jj respectively) allows a state to provide coverage of prescriptions for its SCHIP program for targeted, low-income children, known in New Jersey as NJ FamilyCare. Section 2101 of the Act (42

U.S.C. §1397aa) provides funds to a state to administer the program in an effective and efficient manner.

The Division has reviewed the Federal statutory and regulatory requirements and has determined that the proposed amendments do not exceed Federal standards.

Jobs Impact

The proposed amendments should not have any impact on employment in the State of New Jersey. Jobs are not expected to be either gained or lost as the result of the proposed amendments.

Agriculture Industry Impact

The proposed amendments are not expected to impact on the agriculture industry in New Jersey.

Regulatory Flexibility Analysis

The proposed amendments will affect only dental services providers. Most of these providers may be considered small businesses under the terms of the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. The amendments do not impose additional recordkeeping, compliance, or reporting requirements on small businesses beyond what would ordinarily be required for ordinary business purposes in a professional office. The amendments remove a requirement for prior authorization, which is currently imposed on dental service providers, and allow dentists to bill for the additional time required for patients with developmental and other disabilities who need the additional time.

The providers are required to maintain records to fully disclose the name of the beneficiary who received the service, date of service, and any additional information as may be required by regulation (N.J.A.C. 10:56) and statute (N.J.S.A. 30:4D-6, 7, and 12). The application and billing processes are not changed by this proposal. The requirement for prior authorization when behavior management billing is used has been removed by this proposal. The removal of this regulatory requirement is expected to benefit providers, while assuring that quality services are provided to beneficiaries. All services amended by this proposal must be provided by a professional, that is, a dentist licensed by the state in which he or she practices. There are no other professional services required by the rules. The requirement that services be provided by a licensed dentist must be equally applicable to all providers regardless of business size, because applicable State and Federal law do not allow any accommodation based on business size. Therefore, no differentiation based on business size has been provided in the rules.

Smart Growth Impact

The Department anticipates that the proposed amendments will have no impact on smart growth in New Jersey or on the implementation of the New Jersey State Development and Redevelopment Plan.

Full text of the proposal follows (additions indicated in boldface **thus**; deletions indicated in brackets **[**thus**]**):

CHAPTER 56
DENTAL SERVICES

SUBCHAPTER 1. DENTAL SERVICES; GENERAL PROVISIONS

10:56-1.2 Definitions

The following words and terms, when used in this subchapter, shall have the following meanings unless the context clearly indicates otherwise.

. . .

"Non-routine dental service" means any dental service that requires prior authorization by a Medicaid**/NJ FamilyCare** dental consultant in order to be reimbursed by the New Jersey Medicaid**/NJ FamilyCare** program.

. . .

"Program" means the New Jersey Medicaid**/NJ FamilyCare** program.

"Prior authorization" means approval by a dental consultant to the New Jersey Medicaid**/NJ FamilyCare** program before a service is rendered.

. . .

"Routine dental service" means any dental service that is reimbursable by the New Jersey Medicaid**/NJ FamilyCare** program without authorization by a Medicaid**/NJ FamilyCare** dental consultant.

. . .

10:56-1.3 Provisions for provider participation

(a) A Doctor of Dental Medicine (DMD) or a Doctor of Dental Surgery (DDS), pursuant to N.J.A.C. 13:35 (incorporated herein by reference), who is authorized to provide dental and surgical services by the State of New Jersey, who is an approved Medicaid/NJ FamilyCare fee-for-service participating provider in accordance with (b) below, who complies with all of the rules of the New Jersey Medicaid/NJ FamilyCare fee-for-service programs, shall be eligible to provide dental and surgical dental services to Medicaid/NJ FamilyCare fee-for-service beneficiaries.

1. Any out-of-State dentist may provide dental and surgical services under this Program if he or she meets the documentation and licensing requirements in the State which he or she is practicing, and is a New Jersey Medicaid**/NJ FamilyCare** participating provider.

2. (No change.)

(b) In order to participate in the Medicaid**/NJ FamilyCare** program as a dentist, a dental practitioner shall apply to, and be approved by the New Jersey Medicaid**/NJ FamilyCare** program. An applicant shall complete and submit the "Medicaid Provider Application" (FD-20) and the "Medicaid Provider Agreement" (FD-62). The FD-20 and FD-62 can be found as Forms #8 and #9 in the Appendix at the end of the Administration Chapter (N.J.A.C. 10:49), and may be obtained from and submitted to:

Unisys Corporation
Provider Enrollment
PO Box 4804
Trenton, NJ 08640-4804

(c) Upon signing and returning the Medicaid**/NJ FamilyCare** Provider Application, the Provider Agreement and other enrollment documents to the fiscal agent for the New Jersey Medicaid**/NJ FamilyCare** program, the dentist will receive written notification of approval or disapproval. If approved, the dentist will be assigned a Medicaid**/NJ FamilyCare** Provider Billing Number, a Medicaid**/NJ FamilyCare** Provider Service Number, and will be provided with an initial supply of pre-printed claim forms.

10:56-1.4 Prior authorization

(a) All Dental Service Prior Authorization Forms (MC-10A)**, with the Dental Claim Form (MC-10) attached,** shall be submitted to:

Division of Medical Assistance and Health Services

Office of Utilization Management
Dental Claims Review Unit Mail Code 21
PO Box 713
Trenton, New Jersey 08625-0713
Telephone: (609) 588-7136 or 1-800-782-0181

1. – 2. (No change.)

3. Those services which do not require prior authorization have no asterisk or crosshatch indicators and are those basic services defined by Medicaid**/NJ FamilyCare** as "Routine Services."

4. (No change.)

(b) – (c) (No change.)

(d) Prior authorized ("Non-routine") services shall be completed within one year of the date of authorization by the Medicaid**/NJ FamilyCare** dental consultant.

1. If providers are unable to complete the services within the prior authorized period, providers may contact the Medicaid**/NJ FamilyCare** dental consultant and request a change in the prior authorization request, in accordance with (c)1 above.

2. (No change.)

10:56-1.5 Basis for reimbursement

(a) – (c) (No change.)

(d) Partial reimbursement for an appliance completed but not delivered to the recipient because of circumstances beyond the control of the provider will be authorized by the New Jersey Medicaid**/NJ FamilyCare** program. An amount equivalent to the professional component for inserting and adjusting the appliance will be deducted from the total reimbursement for such appliance. In the event the recipient returns and the service is completed, the provider may request reimbursement for the deducted amount. Procedures as outlined in (c) above will apply.

(e) – (f) (No change.)

(g) When other health or liability insurance is available, the Medicaid**/NJ FamilyCare** program requires that such benefits be utilized first and to the fullest extent. See New Jersey Administrative Code 10:49-7.3 Third Party Liability Benefits for further information. Supplemental payment shall be made by the Medicaid**/NJ FamilyCare** program up to the provider's customary and usual fee, if the combined total does not exceed the amount payable under the Medicaid**/NJ FamilyCare** program.

1. (No change.)

2. Medicare coinsurance and deductible shall be payable by the New Jersey Medicaid**/NJ FamilyCare** program in combination Medicare/Medicaid cases.

10:56-1.8 Non-covered services

(a) A non-covered service is that procedure which is primarily for cosmetic purposes, for which dental necessity cannot be demonstrated, or which is determined to be beyond the scope of the Program by a Medicaid**/NJ FamilyCare** dental consultant as specified in this chapter.

(b) – (c) (No change.)

10:56-1.9 Recordkeeping requirements

(a) – (b) (No change.)

(c) A dentist who provides services for a nursing facility recipient (regardless of the place of service) shall, in addition to maintaining his or her own office records, provide the nursing facility with an entry for the recipient's clinical record that includes the following:

1. (No change.)

i. If a current examination is required within six months of a previous examination performed by the same provider and billed to Medicaid**/NJ FamilyCare**, the results of the original examination shall be entered into the clinical record as the current dental status.

2.–3. (No change.)

10:56-1.10 Utilization review, quality control, peer review, and TAMI review

(a) -- (d) (No change.)

(e) Dental review is the current ongoing review of the degree of quality in the delivery of continuing dental services and health care which is constantly monitored and maintained by the provision of direction, coordination and regulation through the cooperative efforts between representatives of the New Jersey Medicaid**/NJ FamilyCare** Program and a qualified body of peers.

(f) – (g) (No change.)

SUBCHAPTER 2 PROVISIONS FOR SERVICES

10:56-2.1 Dental treatment plan

(a) In accordance with good dental practice, a plan of treatment shall be developed and described for each Medicaid**/NJ FamilyCare** patient on the Dental Services Claim Form (MC-10) following a comprehensive examination. If no treatment is necessary, this fact must be entered on the Dental Services Claim Form (MC-10) under Remarks (Item 20). (No Other Treatment Necessary or NOTN).

(b) Any dental treatment plan, including those not requiring prior authorization, may be reviewed by dental consultants of the New Jersey Medicaid**/NJ FamilyCare** program.

(c) – (g) (No change.)

10:56-2.2 Standards of service

(a) – (b) (No change.)

(c) Experimental procedures, not approved by the New Jersey Board of Dental Examiners (N.J.A.C. 13:30), are not reimbursable by the New Jersey Medicaid**/NJ FamilyCare** program.

(d) (No change.)

10:56-2.4 Place of service

(a) (No change.)

(b) Services should be provided in any appropriate setting, governed by medical/dental necessity and not by the convenience or desires of the beneficiary or the providers of services.

1. Policies specific for dental services rendered in the outpatient departments of approved licensed hospitals and services rendered in approved independent clinics are described in, N.J.A.C. 10:52 and N.J.A.C. 10:66, respectively.

i. Hospital outpatient dental clinics are subject to the same New Jersey Medicaid**/NJ FamilyCare** program policies, procedures and reimbursement schedule, as outlined in this manual, that apply to the dentist in "private" practice (see N.J.A.C. 10:52-2.3(a).)

2. Dental services performed on an inpatient basis in approved licensed hospitals are reimbursable provided that they require that level of care which shall be documented on the hospital records.

i. Dental services are also reimbursable if the beneficiary is admitted for an eligible non-dental condition and the dental services are rendered as part of the prescribed treatment for such condition, or to alleviate the beneficiary's discomfort during the period of hospitalization.

(1) – (2) (No change.)

(3) Authorization by a dental consultant of the Medicaid**/NJ FamilyCare** program is for services only and does not authorize the place of service; thus such authorization does not guarantee payment.

(4) (No change.)

(c) (No change.)

10:56-2.7 Diagnostic services: radiography

(a) – (e) (No change.)

(f) Reimbursement for dental radiographs shall be limited according to the following standards:

1. A complete series radiographic study is defined and limited by age. It represents the maximum number of diagnostic radiographs reimbursable as a single radiographic study every three years without prior authorization as follows:

i. – iii (No change.)

iv. A complete series radiographic study may include two bitewing or more radiographs. Any additional films over and above that number, as limited by age, are considered to be part of that complete series and no additional reimbursement can be made. If, however, extenuating circumstances exist, the need for additional films in (f)1i through iii above must be substantiated and a specific authorization obtained from the Medicaid**/NJ FamilyCare** dental consultant.

v. – vii. (No change.)

(g) – (i) (No change.)

10:56-2.8 Diagnostic services: Clinical laboratory services

(a) (No change.)

(b) Services provided by any of the above laboratories must be billed directly to the Medicaid**/NJ FamilyCare** program by the laboratory, and not by the dentist.

(c) (No change.)

10:56-2.10 Restorative services

(a) Restorative treatment shall be limited to those services necessary to adequately restore and maintain the integrity and contours of the natural tooth, as follows:

1. Filling restorations shall be reimbursed as follows:

i. Reimbursement for restorations in primary teeth shall be limited to primary cuspids and molars of children up to and including age nine, or in primary incisors up to and including age five, but not where exfoliation is imminent, except when prior authorization by a Medicaid/NJ Family Care dental consultant has been obtained by the provider.

ii. Silver amalgam and composite restorations may be provided on anterior and posterior teeth (numbers 1 through 16 and 17 through 32). The provider should select the restorative material most appropriate for the beneficiary's dental needs.

iii. Reimbursement for a restoration will include treatment of pulp exposure, lining or base, restoration, polishing of restoration, and local anesthesia.

iv. Plastic, acrylic, or unfilled resin restorative material shall be reimbursable only when utilized for the six anterior teeth in each arch.

v. Silicate restorations shall not be covered by the New Jersey Medicaid/NJ Family Care fee-for-service programs.

vi. A procedure code shall be selected on the basis of the number of surfaces restored per individual tooth (not on the basis of individual restorations); therefore, the fee for any surface shall include one or more restorations on that surface.

vii. Only one code is reimbursable per tooth except when amalgam and composite resin restorations are placed on the same tooth.

viii. Reimbursement for an occlusal restoration includes any extensions onto the occlusal one-third of the buccal or lingual surface(s) of the tooth.

ix. Extension of interproximal restorations into self cleansing areas will not be considered as additional surfaces. An additional surface will be reimbursable only when the buccal (facial) or lingual margin extends beyond the proximal one-third of the buccal (facial) and/or lingual surface(s).

2. Crown restorations shall be reimbursed as follows:

i. **[**Prior authorization**]** **Reimbursement** for crowns shall be **[**granted**]** **provided** only when there is substantial loss of tooth structure and the condition of the remaining teeth and supporting tissue justify this treatment. **[**Radiographic studies shall be submitted with the prior authorization request. Prior authorization is not necessary for beneficiaries up to and including age 20. Prior authorization is necessary for beneficiaries age 21 and older.**]**

ii. Generally, temporary (quick cure) acrylic or plastic (prefabricated) crowns shall be reimbursable only for badly broken down anterior teeth up to and including age 15. Likewise, preformed stainless steel crowns shall be reimbursable only for primary teeth and permanent posterior teeth up to and including age 17.

iii. Acrylic or porcelain veneer on metal shall be authorized when aesthetically necessary.

iv. Porcelain jackets will not be **[**authorized**]** **reimbursed**.

3. Post and post and core shall be reimbursable under the following conditions:

i. A post is reimbursable on an endodontically treated tooth in conjunction with amalgam, composite, other resin or crown restorations.

ii. A post and core is reimbursable on an endodontically treated tooth only in conjunction with a crown as the final restoration.

iii. A post or post and core on an endodontically treated tooth must extend into at least one-half, and preferably two-thirds, of the length of the endodontically treated canal. Failure of a post or post and core which results in the concurrent failure of a crown will be subjected to recovery of the reimbursement for both services based on this standard.

10:56-2.11 Endodontia

[(a) Some endodontic treatment shall require PA, as indicated in N.J.A.C. 10:56-3.5. Prior authorization will be at the discretion of the Medicaid/NJ Family Care fee-for-

service dental consultant and will be influenced by the age and general health of the beneficiary; the status of the tooth in the arch; and the condition of the remaining dentition and supporting structures.**]**

[(b)**]** **(a)** Reimbursement for root canal therapy for all teeth shall include pulpal extirpation, endodontic treatment to include complete filling of the root canal(s) with permanent material, all necessary radiographs during treatment, a radiograph demonstrating proper completion, and follow-up care.

[1. Prior authorization is necessary for beneficiaries 21 and older. When the beneficiary is in pain, the dentist should institute emergency measures to extirpate the pulp and/or relieve the pain only until authorization is requested and received. Authorization shall not be necessary for beneficiaries up to and including age 20.**]**

[2.**]** **1.** Silver points are not acceptable as the "permanent material" for filling the root canal.

[3.**]** **2.** Complete filling of the root canal is defined as filling of the canal to within 0.5 millimeters of the apex.

(c) – (i) (No change.)

10:56-2.12 Periodontal treatment

(a) Reimbursement shall be provided for periodontal services for up to eight quadrants annually without prior authorization.

[(a)**]** **(b) Additional [P]** **p**eriodontal treatment may be prior authorized by the Division on a very selective basis. Such prior authorization shall be based on the requirements of this section and on the professional judgment of the Division dental consultant. A detailed description of the condition, including radiographs, and photographs where appropriate, shall be submitted to the dental consultant. Photographs or slides are an excellent means of presenting the condition of the oral tissues to the consultant and shall be reimbursable.

[(b)**]** **(c)** When requesting periodontal treatment, consideration should be given to the age and health of the beneficiary, the amount of bone loss, the condition of the remaining dentition, the desire, ability, and motivation of the beneficiary to follow through with necessary home and follow-up care, and the prognosis for the remaining teeth.

[(c)**]** **(d)** When requesting prior authorization of the code for periodontal scaling and root planing, the provider should submit, in addition to radiographs and photographs, a

narrative, to include periodontal pocket depth for each tooth in the quadrant(s) requested.

[(d)**]** **(e)** Reimbursement will be based upon quadrants, a portion thereof, or the equivalent thereof, as determined by Medicaid/NJ Family Care dental consultant in accordance with N.J.A.C. 10:56-3.1(d)6vi.

10:56-2.14 Exodontia and oral surgery

(a) Exodontia rules are as follows:

1. Extraction of teeth other than those classified as non-restorable shall require prior authorization.

i. – ii. (No change.)

(1) That such orthodontic treatment has met the Salzmann Handicapping Malocclusion Guidelines established by the New Jersey Medicaid**/NJ FamilyCare** Program or has been prior authorized through the Chief, Bureau of Dental Services, Division of Medical Assistance and Health Services.

(2) That such extraction(s) has the express consent of the practitioner to whom orthodontic treatment has been authorized. Reimbursement will be denied (or if already paid, reimbursement will be recovered) for any extraction(s) performed:

(A) In conjunction with orthodontic care if such orthodontic treatment has not met the New Jersey Medicaid**/NJ FamilyCare** guidelines or has not been prior authorized by the Chief, Bureau of Dental Services; or

(B) (No change.)

2. – 3. (No change.)

(b) – (d) (No change.)

10:56-2.15 Orthodontic treatment

(a) (No change.)

(b) Orthodontic treatment shall be selective and limited to handicapping malocclusions. Cases with 24 or more points on the New Jersey Handicapping Malocclusion Assessment System shall be considered as having a handicapping malocclusion and prior authorization shall not be required.

1. (No change.)

2. The following factors shall be considered by a dentist before making any referral and also by the practitioner who may render orthodontic treatment before assessing the beneficiary and performing the diagnostic work-up:

i. The assessment system is a modification of the work of Dr. J. A. Salzmann who has consented to allow the New Jersey Medicaid**/NJ FamilyCare** program to modify and utilize it.

ii. The difference from Dr. Salzmann's original work is that the New Jersey Medicaid**/NJ FamilyCare** program does not allow the eight additional points to denote aesthetic handicap for the anterior segment.

iii. – vi. (No change.)

(c) The New Jersey Medicaid**/NJ FamilyCare** Program Handicapping Malocclusion Assessment System shall be utilized to determine if the case fulfills the requirements for a diagnostic workshop and subsequent orthodontic treatment.

1. A reprint from the American Journal for Orthodontics (10/68) entitled "Handicapping Malocclusion Assessment to Establish Treatment Priority" provides comprehensive instructions for completion of the Handicapping Malocclusion Assessment Record Form (FD-10). A copy of the reprint can be ordered from the Medicaid**/NJ FamilyCare** fiscal agent:

UNISYS
PO Box 4811
Trenton, New Jersey 08650-4811

(d) Procedures to be followed by the practitioner are:

1. (No change.)

2. If the malocclusion does not meet the minimum number of assessment points (24), the practitioner should not proceed with the diagnostic workup since the case does not qualify and reimbursement will be denied.

i. (No change.)

ii. For reimbursement of the Handicapping Malocclusion Assessment Examination only, the practitioner shall submit the Dental Services Claim Form (MC-10) directly to the Medicaid**/NJ FamilyCare** fiscal agent:

UNISYS
PO Box 4811
Trenton, New Jersey 08650-4811

iii. (No change.)

3. (No change.)

(e) Certain procedures set forth in (d) above require prior authorization. The rules concerning prior authorization for special orthodontic cases are:

1. (No change.)

2. A consultant of the New Jersey Medicaid**/NJ FamilyCare** program will review the plan of requested treatment utilizing the diagnostic aids submitted and render a decision.

3. The practitioner will be notified by the Medicaid**/NJ FamilyCare** program of the action taken on the treatment request following review by the Medicaid**/NJ FamilyCare** dental consultants.

(f) – (j) (No change.)

10:56-2.16 Pedodontia: pediatric dentistry

(a) – (b) (No change.)

(c) The HCPCS code D0150 EP is reimbursed at an enhanced rate of $25.00 for a specialist and $21.00 for a non-specialist. Reimbursement for a comprehensive clinical oral examination of a child, through age 20 years, is limited to once every six months, except as authorized by a Dental Consultant of the New Jersey Medicaid**/NJ FamilyCare** program. As a minimum, the examination must include:

1. – 7. (No change.)

10:56-2.18 Adjunctive general services: prescriptions

(a) This section is intended to describe the practitioner's responsibility in the writing of prescriptions in order to maintain the traditional beneficiary- prescriber-provider relationship, and to insure the beneficiary free choice of provider. Practitioners are urged to familiarize themselves with all aspects of this section in order to effect economies consistent with good medical/dental practices and to facilitate prompt payment to the provider.

1. The New Jersey Medicaid**/NJ FamilyCare** program will reimburse pharmaceutical providers for prescriptions prescribed by a dentist within the scope of their practice as defined by the State of New Jersey or the state in which they are practicing.

2. The New Jersey Medicaid**/NJ FamilyCare** program has an approved generic formulary (see N.J.A.C. 8:71). The prescriber shall give preference to generic drugs of equal therapeutic effectiveness if available at a lower cost than proprietary or brand named drugs. When prescribing a brand named multi-source drug product for which a maximum allowance cost (MAC) limitation has been established by the Secretary of the Department of Health and Human Services, the prescriber must indicate either substitution allowed or write brand medically necessary on each written prescription. When prescribing a non-MAC brand named drug, the prescriber may indicate either substitution allowed or dispense as written (DAW) on each written prescription.

i. (No change.)

(b) The practitioner's individual Medicaid**/NJ FamilyCare** Provider Service Number shall appear on all prescriptions, and shall be given to the pharmacist with all telephone orders. The appearance of this number in addition to the practitioner's name serves to expedite the mechanical aspects of processing the prescription claim. This requirement is a necessary and efficient step in computing each claim.

(c) – (i) (No change.)

10:56-2.19 Adjunctive general services; medical/dental/supplies

Following receipt of a prescription from the dentist, prior authorization from the **[**Medicaid District Office**]** **Medical Assistance Customer Center** must be obtained by the provider (pharmacist or medical supply dealer) for certain medical/dental supplies; therefore, the practitioner must be prepared to certify and document medical/dental necessity to the dental consultant.

10:56-2.21 Pharmaceutical; program restrictions affecting payment for prescribed drugs

(a) The choice of prescribed drugs shall be at the discretion of the prescriber within the limits of applicable laws. However, the prescriber's discretion is limited for certain drugs. Reimbursement shall be denied (except for dentist's prescriptions) if the requirements of the following rules are not met:

1. – 12. (No change.)

13. Diabetic testing materials, including blood glucose reagent strips, urine

monitoring strips, tapes, tablets, and lancets. Electronic blood glucose monitoring devices or other devices used in the monitoring of blood glucose levels are considered medical supplies and are covered services by Medicaid**/NJ FamilyCare**. These services require prior authorization from the **[**Medicaid District Office (MDO)**]** **Medical Assistance Customer Center (MACC)**. (See Medical Supplier Services chapter, N.J.A.C. 10:59.)

SUBCHAPTER 3 **[**HCFA**]** **HEALTHCARE** COMMON PROCEDURE CODING SYSTEM (HCPCS)

10:56-3.1 Introduction

(a) The New Jersey Medicaid**/NJ FamilyCare** program utilizes the level 3 HCPCS coding system. This system is patterned after the **[**Health Care Financing Administration's (HCFA)**]** **Centers for Medicare & Medicaid Services (CMS) Healthcare** Common Procedure Coding System (HCPCS). The dental HCPCS, although a level 3 state-defined HCPCS, are patterned after some of the Medicare level 2 HCPCS. The allowable assigned codes and modifiers which contain both alphabetic and numeric characters follow the HCPCS rules.

(b) – (e) (No change.)

(f) Listed throughout this subchapter are some general and specific policies of New Jersey Medicaid**/NJ FamilyCare** program relevant to HCPCS. For complete and specific policies in addition to those outlined herein, the practitioner must consult subchapter 1 and/or 2.

1. – 6. (No change.)

(g) (No change.)

10:56-3.2 D0100-D0999 DIAGNOSTIC

(a) Clinical Oral Examination:

IND	HCPCS Code	Mod	Procedure Description	Maximum Fee Allowance S	$	NS
	D0150		Comprehensive oral evaluation	**[**14.00**]** **15.00**	**[**13.00**]** **14.00**	

NOTE 1: (No change.)

NOTE 2: (No change.)

NOTE 3: For reimbursement of the comprehensive oral evaluation with code D0150:

a. The examination is limited to once every six months for patients under 21 years of age and every 12 months for patients over 21 years of age, except as authorized by a dental consultant of the New Jersey Medicaid**/NJ FamilyCare** program;

b. – c. (No change)

. . .

D0150 EP Comprehensive oral evaluation 25.00 21.00

NOTE 1: (No change.)

NOTE 2: (No change.)

NOTE 3: For reimbursement of the comprehensive oral evaluation with code D0150 EP:

a. The examination is limited to once every six months for patient under 21 years of age, except as authorized by a dental consultant of the New Jersey Medicaid**/NJ FamilyCare** program;

b. – c. (No change.)

D0120 Periodic Oral Evaluation **[**14.00**]** **15.00** **[**13.00**]** **14.00**

NOTE: An evaluation performed on a patient of record to determine any changes in the patient's oral health status since a previous initial or periodic examination.

D0120 EP Periodic Oral Evaluation 14.00 13.00

NOTE: (No change.)

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(b) – (c) (No change.)

10:56-3.6 D4000-D4999 PERIODONTICS

(a) Surgical services (including usual post-operative services):

IND	HCPCS Code	Mod	Procedure Description	Maximum Fee Allowance S	$	NS
[*] #	D4210		Gingivectomy or Gingivoplasty --Per Quadrant	43.60		37.50
*	D4211		Gingivectomy or Gingivoplasty --Per Tooth	6.00		5.50

NOTE: Maximum number of teeth reimbursable--Three.

NOTE 2: D4210 PA required only when exceeding four (4) quadrants, twice annually

[*] #	D4220		Gingival Curettage, Surgical --Per Quadrant	22.50	19.50
[*] #	D4260		Osseous Surgery (Including Flap Entry and Closure)--Per Quadrant	75.00	64.50
#	**D4261**		**Osseous, Single Site**	**56.25**	**48.40**
*	D4263		Bone Replacement Graft First Site in Quadrant	261.00	261.00
*	D4264		Bone Replacement Graft— Each Additional Site in Quadrant (Use if Performed on Same Date of Service)	130.50	130.50
[*] #	D4270		Pedicle Soft Tissue Graft Procedure	32.00	28.00

NOTE **1**: Per site.

NOTE 2: D4220, D4260, D4261, D4270 PA required only for services exceeding four (4) quadrants, twice annually.

[*] #	D4271		Free Soft Tissue Graft Procedure (Including Donor Site)	49.00	42.00

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(b) Adjunctive periodontal services:

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[*] #	D4341	Periodontal Scaling and Root Planing--Per Quadrant	37.50	34.50

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NOTE 1: (No change.)

NOTE 2: (No change.)

NOTE 3: D4341 PA required for services exceeding four (4) quadrants, twice annually

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10:56-3.10 D7000-D7999 ORAL SURGERY

(a) – (f) (No change.)

(g) Removal of tumors, cysts, and neoplasms:

1. In the excision and management of this type of lesion, a biopsy report must be available for review by the Medicaid**/NJ FamilyCare** dental consultants.

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(h) – (o) (No change.)